



HEARTS ENTERAL, LLC.
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 Web: www.compassionworksmrs.com (sister company)

**HIPAA Compliant
 (Health Insurance Portability and
 Accountability Act of 1996)**

Patient Intake Form

THIS IS NOT AN ORDER FORM TO ORDER SUPPLIES

PATIENT INFORMATION			
<u>FIRST NAME</u>	<u>MIDDLE INITIAL</u>	<u>LAST NAME</u>	
<u>DATE OF BIRTH</u> / /	<u>AGE</u>	<u>SS # (Optional)</u>	<u>GENDER</u> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
<u>STREET ADDRESS</u>	<u>APT#</u>	<u>CITY</u>	<u>STATE</u> <u>ZIP</u>
<u>EMAIL ADDRESS</u>	<u>EMPLOYMENT STATUS</u> <input type="checkbox"/> CHILD <input type="checkbox"/> EMPLOYED F/T <input type="checkbox"/> EMPLOYED P/T <input type="checkbox"/> UNEMPLOYED <input type="checkbox"/> DISABLED <input type="checkbox"/> SELF-EMPLOYED <input type="checkbox"/> STUDENT <input type="checkbox"/> OTHER		
<u>PHONE</u>	<u>WORK NUMBER</u>	<u>OTHER PHONE</u>	
GENETIC DISORDER			
<u>MEDICAL CONDITION</u>	<u>CURRENT SUPPLIES</u>	<u>AMOUNT PER MONTH</u>	<u>CURRENT DME/PHARM</u>
CLINIC INFORMATION			
<u>PHYSICIAN/APRN/DO</u>	<u>CLINIC & CONTACT NAME</u>	<u>PHONE #</u>	<u>FAX #</u>
RESPONSIBLE PARTY / PARENT / CAREGIVER (GUARANTOR) INFORMATION			
RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER _____			
<u>LAST NAME</u>	<u>FIRST NAME</u>	<u>MIDDLE INITIAL</u>	<u>PHONE NUMBER #</u>
PRIMARY INSURANCE INFORMATION			
<u>INSURANCE NAME</u>	<u>PHONE NUMBER</u>	<u>MEMBER ID #</u>	<u>GROUP #</u>
<u>MEMBER NAME</u>	<u>MEMBERS DATE OF BIRTH</u>	<u>RELATIONSHIP TO MEMBER</u>	
SECONDARY INSURANCE INFORMATION			
<u>INSURANCE NAME</u>	<u>PHONE NUMBER</u>	<u>MEMBER ID #</u>	<u>GROUP #</u>

Authorization for Release of Health Information: I HEREBY AUTHORIZE RELEASE OF HEALTHCARE INFORMATION. This information contained herein may be shared to Hearts Enteral, LLC and its affiliates for quality purposes to ensure that the necessary resources are available to service you for medical nutrition, medical supplies, and supplier distribution. Such information is furnished in compliance with HIPAA to allow for the best service. I also understand and agree to Hearts Enteral's Notice of Privacy Practices. Nonetheless, if you do not wish for this information to be shared with Hearts Enteral, LLC. call (973) 832-4736 and our HIPAA Privacy Officer will assist you with this request and ensure that the information is not shared.

Signature of applicant: _____ Date: _____

Representative of applicant: _____ Date: _____

Representative Title: _____

IMPORTANT: PLEASE FAX , MAIL (above) OR EMAIL COMPLETED FORM TO: HEARTS ENTERAL, LLC., ATTN: Patient Intake, Confidential HIPAA FAX# (973) 387-1223.

PLEASE ATTACH A PERSCRIPTION, LETTER OF MEDICAL NECESSITY, RESENT CLINICAL NOTES, and copy of insurance card (front & back)* * *